APPEAL NO. 93052

On November 17, 1992, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The issues considered were whether the claimant, (who is the appellant in this case), sustained a back injury at the same time he sustained a work-related knee injury on (date of injury) while employed by (employer), and whether the claimant had reached maximum medical improvement (MMI), as reported by the designated doctor. The hearing officer determined that claimant did not sustain a back injury at the same time his knee was injured, and that the report of the designated doctor was entitled to presumptive weight and was not contrary to the great weight of the other medical evidence. The hearing officer determined that the claimant has therefore attained MMI for his knee injury effective May 11, 1992 with a permanent impairment rating of three percent.

The claimant has appealed this decision generally without specifying what he believes was erroneous. Because the claimant asks for payment of temporary income benefits (TIBS), it appears that the claimant disputes the finding that he has achieved MMI. The claimant points out the reasons why he feels the designated doctor was prejudiced in his evaluation of his condition. The claimant also asks for proper medical treatment for the numbness in his knee. The carrier responds by asking that the decision be upheld.

DECISION

After reviewing the record, we affirm the determination of the hearing officer.

I

The evidence summarized here comes from testimony and records in the case.

The claimant was walking in a muddy area and slipped, sustaining a twisting injury to his right knee. He ultimately had arthroscopic surgery on his knee, on November 22, 1991, to repair a torn lateral meniscus muscle, and physical therapy, under the guidance of his treating doctor, Dr. S (Dr. S). Dr. S's records indicated that on January 6, 1992 claimant complained that he could not walk. Dr. S noted a nearly normal gait and lack of swelling, but with "global tenderness" in the knee. Dr. S stated an impression that claimant was likely exacerbating his symptoms. An MRI of the knee was performed at Dr. S's direction on January 7, 1992. The conclusion was "normal post meniscectomy changes of the medial meniscus with a small joint effusion." After this, Dr. S recommended another month of therapy because of reported soreness in the knee.

On February 13, 1992 the claimant sought treatment from (Dr. M), of the Department of (clinic). Dr. M's letter indicates that claimant complained of popping and knee pain, and that the claimant felt that surgery had not significantly changed his symptoms. Dr. M noted knee pain and swelling of unknown etiology. On March 2, 1992 Dr. M noted complaints from claimant of "numbness" in the knee when standing for a prolonged period of time. Dr. M noted an impression of slow recovery following surgery, with continuing physical therapy.

On April 2nd Dr. M noted more complaints of numbness and tingling, but noted on physical examination of the knee there was little that was abnormal.

On May 11, 1992 Dr. M discharged claimant from his care relating to his knee. Dr. M stated that he found little reason for claimant to restrict his activities regarding his knee. He noted: "I don't believe that there is any further knee surgery that is going to change his symptoms" and "I reassured him that I understand that he has a problem in his knee that makes it not totally normal, but it should be well enough for him to do just about any work he feels up to." Dr. M stated his concern that claimant "may have had an occult injury to his back at the same time of his knee and his numbness may be related to the back disc injury or nerve root compression." He suggested that claimant consult with one of his colleagues for this. However, even though he made this suggestion, Dr. M completed a TWCC-69 form, Report of Medical Evaluation, and stated that the claimant had reached MMI effective May 11, 1992 with a three percent permanent impairment.

The claimant made plain to the hearing officer that during the time of his treatment he never claimed that he had also sustained a back injury. The claimant said that the first suggestion of this was made by Dr. M to him, not by him. This is supported by the letters from Dr. M. Claimant stated that the carrier refused to pay for the recommended spinal exam; the carrier subsequently disputed the claim of a back injury. The claimant's argument during the hearing is that the recommendation made by Dr. M was for treatment for the numbness in his knee.

The record does not show who requested the appointment of a designated doctor. The Commission appointed (Dr. W), an orthopedic surgeon, as the designated doctor on July 2, 1992. On that date, the Commission wrote to the adjuster, placing upon him the responsibility to make an appointment and inform the Commission and claimant. The adjuster was told to furnish all relevant medical reports, records, and tests to the doctor, as well as an accurate job description. The adjuster for the insurance company wrote to the designated doctor on July 13, 1992 to confirm the appointment to examine claimant and to forward medical records. The letter, however, inaccurately characterized Dr. W as the third designated doctor on the case, and then set out apparent historical information on the claim, overlaid, it must be frankly stated, with some characterization of the author's view of claimant's motives. After indicating that Dr. M had previously assessed MMI and three percent impairment, the letter comments: "[w]hen the claimant realized that he was being released from the doctor's care, he then indicated to [Dr. M] that he now had a back injury." It is not evident from the letter if a job description was furnished to the doctor.

The claimant was examined by Dr. W on July 24, 1992. The claimant stated that he felt that Dr. W was cold and aloof, trying not to be hostile. He stated, however, that his knee was examined. The claimant indicated that he believed that Dr. W had his medical records. He denied that he told Dr. W, as indicated in Dr. W's report, that he had injured his back on

(date of injury). He stated that he felt that Dr. W's report essentially repeats the adjuster's viewpoint of the case, and indicates that Dr. W did not review his records thoroughly because he would have seen that Dr. M was the first person to raise an issue of a possible back injury. Claimant said that Dr. W told him there was no medical reason for the numbness in his knee. Dr. W issued a TWCC-69 report which determined that MMI had been reached on May 11, 1992, with a three percent impairment. He opined that claimant had not sustained a back injury, noting that an x-ray of the back showed some slight traction spurs at L4-5.

Claimant put into evidence results of an MRI examination conducted by (Dr. K) on his lumbar spine conducted on August 12, 1992. The impression is a small central disc herniation at L2-3, and a moderate diffuse disc herniation at L4-5. The report also notes degenerative changes at both levels as well.

The claimant testified that at the time he was examined by the designated doctor, he was represented by an attorney. The claimant represented himself at the September 23, 1992 benefit review conference and the contested case hearing.

II

WHETHER THE HEARING OFFICER ERRED IN CONCLUDING THAT THE CLAIMANT DID NOT SUSTAIN A COMPENSABLE BACK INJURY

As to the claimant's back condition, the MRI performed after the designated doctor's report indicates a couple of small to moderate herniated discs, but also notes that claimant has several degenerative changes in the same area. There is no medical evidence indicating that this condition occurred at the same time that claimant hurt his knee. As the claimant himself pointed out several times, he did not claim that he injured his back. Dr. S's records do not document any complaints of back pain.

Compensation, including medical benefits, can only be paid for injuries or diseases that are work related. The assessment of MMI and impairment is based upon the compensable injury. While an aggravation of a preexisting degenerative condition can be considered an injury, that aggravation must be proven to have occurred on the job. Given the record here, the possibility that the herniations occurred after the on-the-job injury, after the claimant was not working for the employer, or resulted from degenerative conditions, could appear stronger than the likelihood that they happened at the time the knee was hurt. We cannot say that the hearing officer's findings and conclusions that claimant did not sustain a compensable back injury are against the great weight and preponderance of the evidence.

III

THE CLAIMANT'S REQUEST FOR RECOMMENDED MEDICAL TREATMENT

Because the hearing officer determined that claimant did not sustain a back injury in the course and scope of his employment, claimant is not entitled to health care services for treatment of his back injury through workers' compensation insurance. However, the claimant indicated at the hearing that the spinal examination was suggested by Dr. M as treatment to ascertain the reason for numbness in his knee, not for a separate back injury he never claimed. The hearing officer's decision agrees that claimant is still entitled to medical treatment for his compensable knee injury.

But whether health care services for the spine can be paid under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-4.61 (Vernon Supp. 1993) (1989 Act), as necessary treatment of the claimant's knee, is a question that may legitimately be raised by the insurance carrier. *See* Art. 8038-4.68. However, these questions are decided through a different hearing procedure, as set out in Art. 8038-8.26 and related rules. This is why the hearing officer did not specifically order a spinal examination.

IV

WHETHER THE HEARING OFFICER ERRED BY GIVING PRESUMPTIVE WEIGHT TO THE DESIGNATED DOCTOR'S REPORT

The hearing officer was not wrong when he gave presumptive weight to the opinion of the designated doctor in this case, or when he found that the great weight of other medical evidence was not against that report.

The claimant developed a full record on why he felt the designated doctor was not impartial, and the hearing officer's decision indicated that he considered this evidence. To decide whether the designated doctor's report still had value as an assessment of MMI and impairment, however, the hearing officer had to follow the 1989 Act, which states that the "presumptive" weight of a designated doctor's report may only be overcome by the great weight of <u>medical</u> evidence. Art. 8308-4.25(b); 4.26(f). The source of such medical evidence can only be a health care provider, not a lay person. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992.

In this case, the treating doctor's report on MMI and impairment, made even though he thought claimant could have a back injury, reaches the same conclusion as the designated doctor's report. There was no medical evidence or opinion, let alone a great weight, showing that claimant had not reached MMI or that the three percent rating was wrong. Because Dr. W's opinion is the same as Dr. M's opinion on MMI and impairment, the hearing officer evidently decided that Dr. W was not influenced by the insurance adjuster.

The existence of MMI is different from the issue of whether disability, as defined in Article 8308-1.03 (16), exists. Texas Workers' Compensation Commission Appeal No. 91060, decided December 12, 1991. The claimant argued that he is entitled to TIBS because he is still unable to work. But liability of the carrier to pay TIBS, even where an injured employee cannot yet work, ends when MMI is reached. Art. 8308-4.23(b).

MMI will not mean, in all cases, that the injured employee is pain-free or completely restored to the condition he or she was before the injury. This is because the definition of MMI is the earlier of 104 weeks after the date income benefits began to accrue, or "the point after which further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated, based on reasonable medical probability." Art. 8308-1.03(32)(A). The impairment rating is the percentage of "permanent impairment" resulting from the compensable injury. Art. 8308-1.03(24) & (25). A doctor who certifies MMI and also assesses an impairment rating in effect recognizes that the claimant will have some lasting effect from the injury.

Because the claimant reached MMI on May 11, 1992 for his compensable knee injury, the claimant's entitlement to TIBS ended on that date. His entitlement to nine weeks of impairment income benefits began thereafter. Although the claimant's appeal states his belief that his TIBS payments were ended because of alleged lies by the adjuster, the carrier's decision was based upon the treating doctor's report, separate from any disputes which may have developed later between the claimant and the adjuster.

Some of the statements in the adjuster's letter to the designated doctor, which served only to cause anger and loss of confidence in the designated doctor, show why an insurance carrier should refrain from contact with a designated doctor that goes beyond merely forwarding medical records as ordered by the Commission. The designated doctor is established by the 1989 Act to be the impartial doctor for resolution of disputes over MMI and impairment. Consequently, a carrier should refrain from characterizing the information he is ordered to convey, or from furnishing extra nonmedical or background information unless requested to do so by the Commission. It goes without saying that any information furnished by either party to the designated doctor should be accurate and relevant.

The hearing officer is the sole judge of the relevance and materiality, the weight and credibility, of the evidence offered in a contested case hearing. 1989 Act, Art. 8308-6.34(e). The decision of the hearing officer will be set aside only if the evidence supporting the hearing officer's determination is so weak or against the overwhelming weight of the evidence as to be clearly wrong or manifestly unjust. Atlantic Mutual Insurance Co. v. Middleman, 661 S.W.2d 182 (Tex. App.-San Antonio 1983, writ ref'd n.r.e.).

Therefore, we affirm the hearing officer's adoption of the designated doctor's opinion

that MMI had been reached, and that the great weight of other medical evidence was not to the contrary. We further affirm his finding that claimant did not sustain a back injury on (date of injury).

Susan M. Kelley
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Lynda H. Nesenholtz
Appeals Judge